AMENDED IN ASSEMBLY AUGUST 25, 1997

AMENDED IN ASSEMBLY JULY 23, 1997

SENATE BILL No. 1052

Introduced by Senator Vasconcellos

February 27, 1997

An act to amend Sections 10232.1, 10234.93, and 10237.1 of, to amend and renumber Section 10232.8 of, to add Sections 10232.2, 10232.92, 10232.93, 10232.95, 10232.96, 10234.86, 10234.87, 10235.9, 10235.30, 10235.40, 10235.50, 10235.51, 10235.52, 10235.90, 10237.4, 10237.5, and 10237.6 to, and to repeal and add Section 10234.95 of, the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 1052, as amended, Vasconcellos. Insurance: long-term care.

Existing California law regulates long-term care insurance, and requires that insurance to provide certain benefits. Existing law authorizes the Insurance Commissioner to waive certain of those requirements under certain circumstances.

Existing federal law provides that long-term care insurance is entitled to certain favorable tax treatment if it meets certain requirements.

This bill would require every policy that is intended to be a qualified long-term care insurance contract as provided by federal law to be identified as such with a specified disclosure statement, and, similarly would require every policy that is not intended to be a qualified long-term care insurance

contract as provided by federal law *to* be identified as such. It would require insurers that *offer* policies *or certificates* that are intended to be federally qualified long-term care insurance to fairly and affirmatively concurrently offer, market, and sell policies *and certificates* that are not intended to be federally qualified long-term care ~~contracts~~.

The bill would revise various definitions.

Existing law imposes various requirements on the marketing of long-term care insurance, including various disclosure requirements.

This bill would require that a specific shoppers guide be provided to prospective applicants.

The bill would require insurers to make certain reports regarding lapses and replacements.

The bill would require that premium adjustments be made for replacement policies.

The bill would require insurers and other marketers of long-term care insurance to utilize specified suitability standards. It would require that insurers provide notifications regarding denial of claims.

The bill would require insurers to offer or provide certain rights and benefits in connection with long-term care insurance, including rights to increase and decrease benefits. The bill would impose requirements on inflation protection benefits.

The bill would enact related provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds as follows:

(1) Current California law requires that long-term care insurance policies and certificates provide substantial benefits to consumers in return for the premiums paid.

(2) Recent changes in federal law allow for the sale of long-term care policies and certificates that may be eligible for favorable federal tax treatment. However, to be eligible for favorable tax treatment, the policies and

certificates must conform to federal standards for eligibility, benefits, and consumer protections.

(3) Pursuant to federal law, the eligibility requirements for benefits under a ~~"federally tax qualified" policy are~~ *policy intended to be a federally qualified long-term care policy as defined by Public Law 104-191 may be* more restrictive than the eligibility requirements for benefits in policies authorized under the current California Insurance Code. This means that *some* persons who purchase federally tax qualified policies and certificates may be required to have a greater level of disability before qualifying for benefits than individuals who purchase coverage that conforms to the more permissive eligibility requirements of the California Insurance Code as of January 1, 1997.

~~(4) The tax benefits of federally tax qualified policies may not be of value to every Californian, as the tax benefits vary by the age, income, and other medical expenses of the insurance purchaser.~~

~~(5)~~

(4) Many Californians purchase long-term care insurance to protect themselves against the expenses of needing long-term care due to an illness or physical disability.

~~(6)~~

(5) The protection a consumer receives against future long-term care expenses by purchasing long-term care insurance depends in large part upon the inclusion in the policy of certain key consumer protection provisions: protection against erosion of the value of benefits from inflation, against unintentional lapse, and against changes in the personal and financial situation of the purchaser.

~~(7)~~

(6) The National Association of Insurance Commissioners (NAIC) and other distinguished groups have developed standards that insurers and states can adopt to enhance the value of long-term care insurance and protect long-term care insurance purchasers against inflation, lapses, rate increases, and other potential problems.

~~(8)~~

(7) The recently enacted federal Health Insurance Portability and Accountability Act of 1996 mandates that certain consumer protections be included in all policies that are intended to be federally tax qualified but these standards do not apply to policies that are not federally tax qualified.

~~(9) California lags behind many other states in the adoption of important consumer protection standards recommended by the National Association of Insurance Commissioners, the Health Insurance Portability and Accountability Act, and other distinguished groups.~~

(b) The Legislature declares it is in the interest of the people of California that:

(1) California consumers should be given opportunities to purchase both types of policies or certificates—those meeting the ~~current~~ *eligibility* requirements of the California Insurance Code, *but that are not intended to be federally qualified,* and those meeting the requirements to be federally tax qualified.

(2) California consumers should be informed of the choices available and insurers, brokers, agents, and other entities engaged in the marketing of long-term care insurance should fully evaluate each applicant's situation and work to ensure that the applicant purchases a policy best suited to that applicant's personal and financial circumstances.

(3) All long-term care insurance policies sold in California, including those intended to be tax qualified and those that are not, should be governed by a single set of standards that afford California insurance purchasers a high level of consumer protection.

(4) The laws governing the sale of long-term care insurance in California should be updated to incorporate the latest and best consumer protection standards available.

(5) It is the purpose of this act to authorize the sale in California of a new category of long-term care insurance policies and certificates intended to qualify under the federal Health Insurance Portability and Accountability

Act of 1996, Public Law 104-191, and to require that insurers continue to make available to California consumers policies and certificates that comply with the ~~more permissive~~ eligibility requirements of ~~the current law~~ *policies and certificates not intended to qualify for favorable tax treatment under Public Law 104-191*. It is also the intent of the Legislature that consumers be informed of the choice of policies available and given appropriate information to make informed choices.

SEC. 2. Section 10232.1 of the Insurance Code is amended to read:

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: ''This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for~~ federal~~ tax benefits.'' Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: ''This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract.''

(b) Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a ''nursing facility only'' policy or certificate and the words ''Nursing Facility Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a ''home care only'' policy or certificate and the words ''Home Care Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may

approve alternative wording if it is more descriptive of the benefits.

(d) Only those policies or certificates providing benefits for both institutional care and home care may be called ''comprehensive long-term care'' insurance.

SEC. 3. Section 10232.2 is added to the Insurance Code, to read:

10232.2. *(a)* Every insurer that offers policies *or certificates* that are intended to be federally qualified long-term care insurance ~~contracts shall, at the same time,~~ *shall* fairly and affirmatively concurrently offer~~, market, and sell policies~~ *and market long-term care insurance policies and certificates* that are not intended to be ~~a~~ federally qualified ~~long-term care contracts~~ as described in subdivision (a) of Section 10232.1. All long-term care insurance contracts approved after the effective date of this section shall meet the requirements of this chapter. *If a life insurer issues a rider to a life insurance policy providing long-term care insurance coverage, that rider shall meet the requirements of this subdivision.*

(b) Until January 1, 1999, or until 90 days after approval of contracts and policies submitted for approval pursuant to subdivision (a), whichever comes first, insurers may continue to offer, market, and sell previously approved long-term care insurance policies and contracts.

SEC. 4. Section 10232.8 of the Insurance Code is amended and renumbered to read:

10232.9. (a) Every long-term care policy or certificate that purports to provide benefits of home care or community-based services, shall provide at least the following:

(1) Home health care.

(2) Adult day care.

(3) Personal care.

(4) Homemaker services.

(5) Hospice services.

(6) Respite care.

(b) For purposes of this section, policy definitions of these benefits may be no more restrictive than the following:

(1) ''Home health care'' is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker or social work assistant.

(2) ''Adult day care'' is medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

(3) ''Personal care'' is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. ''Instrumental activities of daily living'' include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

(4) ''Homemaker services'' is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

(5) ''Hospice services'' are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a

physician or a multidisciplinary team under medical direction.

(6) ''Respite care'' is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

(c) Home care benefits shall not be limited or excluded by any of the following:

(1) Requiring a need for care in a nursing home if home care services are not provided.

(2) Requiring that skilled nursing or therapeutic services be used before or with unskilled services.

(3) Requiring the existence of an acute condition.

(4) Limiting benefits to services provided by Medicare-certified providers or agencies.

(5) Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.

(6) Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.

(7) Requiring ''medical necessity'' or similar standard as a criteria for benefits.

(d) Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, shall pay a maximum benefit payment for home care that is at least 50 percent of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less than fifty dollars ($50) per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision.

Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, shall allow a similar durational maximum for

home care that is at least one-half of the length of time allowed for institutional care.

~~SEC. 5.5.~~

SEC. 5. Section 10232.92 is added to the Insurance Code, to read:

10232.92. No insurer shall deliver or issue for delivery a long-term care insurance policy in this state unless the insurer offers to the policyholder, at time of application, an option to purchase a long-term care insurance policy that covers assisted living care in a licensed residential care facility or a residential care facility for the elderly as ~~defined in the Welfare and Institutions Code.~~ *defined in the Health and Safety Code and pays a minimum benefit no less than 50 percent of the maximum benefit for institutional care. The option to purchase an assisted living benefit need not be made if coverage for assisted living that pays a minimum benefit no less than 50 percent of the maximum benefit for institutional care is already included in the policy.*

SEC. 6. Section 10232.93 is added to the Insurance Code, to read:

10232.93. Every long-term care policy ~~of~~ *or* certificate shall define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any ~~benefits covered by the policy with no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home and community-based care and the per diem limits for institutional care.~~ *home and community based services defined in Section 10232.9, assisted living benefit defined in Section 10232.92, or institutional care covered by the policy or certificate. There shall be no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home and community based care and for assisted living care, and for the limits for institutional care.*

~~SEC. 6.~~

SEC. 6.3. Section 10232.95 is added to the Insurance Code, to read:

10232.95. Every long-term care policy or certificate that provides reimbursement for care in a nursing facility

shall cover and reimburse for per diem expenses, as well as the costs of ancillary supplies and services, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate.

SEC. 6.5. Section 10232.96 is added to the Insurance Code, to read:

10232.96. When a policy or certificate holder of an insurance contract issued prior to December 31, 1996, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, shall provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice should therefore be sought.

SEC. 7. Section 10234.86 is added to the Insurance Code, to read:

10234.86. (a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Every insurer shall report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapses and replacements as measured by subdivision (a).

(c) Every insurer shall report annually by June 30, the number of lapsed policies as a percent of its total annual sales in the state, as a percent of its total number of policies in force in the state, and as a total number of each policy form in the state, as of the end of the preceding calendar year.

(d) Every insurer shall report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year.

(e) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of

reviewing more closely agent activities regarding the sale of long-term care insurance.

SEC. 8. Section 10234.87 is added to the Insurance Code, to read:

10234.87. *(a)* If an insurer replaces a policy or certificate that it has previously issued, the insurer shall recognize past insured status by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits shall equal five percent of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credit shall be applied toward all future premium payments for the replacement policy or certificate, but the cumulative credit allowed need not exceed 50 percent. No credit need be provided if a claim has been filed under the original policy or certificate.

(b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 9. Section 10234.93 of the Insurance Code is amended to read:

10234.93. (a) Every insurer of long-term care in California shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.

(4) Provide the following continuing education and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following continuing education requirements which shall be part of, and not in addition to, the continuing education requirements in Section 1749.3:

(A) For licensees issued a license after January 1, 1992, eight hours of education in each of the first four 12-month periods beginning from the date of original license issuance and thereafter and eight hours of education prior to each license renewal.

(B) For licensees issued a license before January 1, 1992, eight hours of education prior to each license renewal.

Licensees shall complete the initial continuing education requirements of this section prior to being authorized to solicit individual consumers for the sale of long-term care insurance.

The continuing education required by this section shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, NAIC consumer suitability standards and guidelines, and alternatives to the purchase of private long-term care insurance.

(5) Display prominently on page one of the policy or certificate and the outline of coverage: ‘‘Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.’’

(6) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

(7) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision.

(8) Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

(9) Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.

(b) In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

SEC. 10. Section 10234.95 of the Insurance Code is repealed.

SEC. 11. Section 10234.95 is added to the Insurance Code, to read:

10234.95. (a) Every insurer or other entity marketing long-term care insurance shall:

(1) Disclose at the time of application the differences in eligibility for benefits and tax treatment between policies and certificates that are intended to be, and policies and certificates that are not intended to be, federally qualified long-term care insurance contracts pursuant to Public Law 104-191 and to advise applicants and policyholders to consult with an accountant or tax adviser.

(2) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(3) Train its agents in the use of its suitability standards.

(4) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(b) The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(3) The value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(c) The issuer, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subdivision (b). The efforts shall include presentation to the applicant, at or prior to application, of the ''Long Term Care Insurance Personal Worksheet,'' *contained in the* Long Term Care Insurance Model Regulations~~,~~ *of the* National Association of Insurance Commissioners. The personal worksheet used by the insurer shall contain, at a minimum, the information in the NAIC worksheet in not less than

12-point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed and approved by the commissioner.

(d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses *and dependents*.

(e) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

(f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(g) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to ~~Appendix D~~ *the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners*. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(i) The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet

the suitability standards, and the number who chose to conform after receiving a suitability letter.

(j) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 12. Section 10235.9 is added to the Insurance Code, to read:

10235.9. (a) Every insurer shall report annually by June 30 the total number of claims denied by each class of business in the state and the number of these claims denied for failure to meet the waiting period or because of a preexisting condition as of the end of the preceding calendar year. ~~The department shall make available to the public the denial rate of claims by insurer.~~

(b) The insurer shall provide every policyholder or certificate holder whose claim is denied a written notice within 40 days of the date of denial of the reasons for the denial and all information directly related to the denial. Insurers shall annually report to the department the number of denied claims. ~~The department shall make available to the public the denial rate of claims by insurer.~~

(c) The department shall make available to the public, upon request, the denial rate of claims by insurer.

SEC. 13. Section 10235.30 is added to the Insurance Code, to read:

10235.30. *(a)* No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period nonforfeiture benefit with the following features:

~~(a)~~

(1) Eligibility begins no later than after 10 years of premium payments.

~~(b)~~

(2) The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy.

~~(c)~~

(3) The same benefits are payable, including the amounts and frequency in effect at the time of lapse, for a qualifying claim.

~~(d)~~

(4) The lifetime maximum benefit may be reduced by the amount of any claims already paid.

~~(e)~~

(5) Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.

(b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 14. Section 10235.40 is added to the Insurance Code, to read:

10235.40. (a) No individual long-term care policy or certificate shall be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1) A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read as follows:

‘‘Protection Against Unintended Lapse.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

_____ _____

Signature of Applicant Date’’

(b) The insurer shall notify the insured of the right to change the written designation, no less often than once every two years.

(c) When the policyholder or certificate holder pays the premium for a certified long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision (a) need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified long-term care insurance policy or certificate shall clearly indicate the deduction payment plan selected by the applicant.

(d) No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(e) Each long-term care insurance policy or certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

SEC. 15. Section 10235.50 is added to the Insurance Code, to read:

10235.50. (a) Every policy or certificate shall include a provision that gives the policyholder or certificate holder a right, exercisable any time after the first year, to retain a policy or certificate while lowering the premium in one or more of the following ways:

(1) Reducing the lifetime maximum benefit.

(2) Reducing the nursing facility per diem and reducing the home- and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.

(3) Converting a ‘‘comprehensive long-term care’’ policy or certificate to a ‘‘Nursing Facility Only’’ or a ‘‘Home Care Only’’ policy or certificate, if the insurer issues those policies or certificates for sale in the state.

(b) The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date.

(c) If the contract in force at the time a reduction in coverage is made provides for benefit adjustments for anticipated increases in the costs of long-term care services, then the reduced nursing facility per diem, lifetime maximum benefit, and daily, weekly, or monthly home care benefits shall be adjusted in the same manner and in the same amount as the contract in force prior to the reduction in coverage.

(d) In the event a policy or certificate is about to lapse, the insurer shall advise the insured of the options to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage. The notice shall provide the insured at least 30 days in which to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects the reduced coverage.

(e) In the event of a premium increase, the insured who has already exercised the right to lower premiums and reduce coverage shall be offered one additional option to lower premiums and reduce coverage.

SEC. 16. Section 10235.51 is added to the Insurance Code, to read:

10235.51. (a) Every policy or certificate shall include a provision that gives the insured the option to elect, no less frequently than on each anniversary date after the policy or certificate is issued, to pay an extra premium for one or more riders that increase coverage in any of the following ways:

(1) Increase the amount of the per diem benefits.

(2) Increase the lifetime maximum benefit.

(3) Increase the amount of both the nursing facility per diem benefit and the home- and community-based care benefits of a comprehensive long-term care insurance policy or certificate.

(b) The premiums for the riders to increase coverage will be based on the attained age of the insured. The premium for the original policy or certificate will not be changed and will continue to be based on the insured's age when the original policy or certificate was issued.

(c) The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the additional coverage. The insurer may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.

SEC. 17. Section 10235.52 is added to the Insurance Code, to read:

10235.52. (a) Every policy or certificate shall contain a provision that, in the event the insurer develops new benefits and provisions not included in the previously issued policy or certificate, the insurer will grant current holders of its policies or certificates who are not in benefit or within the elimination period the following rights:

(1) The insured will be notified of the availability of the new benefits and provisions within 12 months.

(2) The insured will be afforded an opportunity to acquire the new benefits and provisions in one of the following ways:

(A) By adding a rider to the existing policy or certificate and paying a separate premium for the new

coverage based on the insured's attained age. The premium for the existing policy or certificate will remain unchanged based on the insured's age at issuance.

(B) By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits shall equal 5 percent of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credits shall be applied toward all subsequent premium payments for the replacement policy or certificate, but the cumulative credits allowed need not reduce the premium for the replacement policy or certificate to less than the premium for the prior policy or certificate. No credit need be provided if a claim has been filed under the prior policy or certificate.

(C) By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.

(b) The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate.

(c) The insurer of a group policy issued to an employer group must offer the group policyholder the opportunity to have the new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the issuer's offer.

SEC. 18. Section 10235.90 is added to the Insurance Code, to read:

10235.90. In the event a non-medicaid national or state long-term care program is created through public funding that substantially duplicates benefits covered by the policy or certificate, the policyholder or certificate holder will be entitled to select either a reduction in

future premiums or an increase in future benefits. An actuarial method for determining the premium reductions and increases in future benefits will be mutually agreed upon by the department and insurers. The amount of the premium reductions and future benefit increases to be made by each insurer will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience. Each insurer's premium reduction and benefit increase plans shall be filed and approved by the department.

SEC. 19. Section 10237.1 of the Insurance Code is amended to read:

10237.1. No insurer may deliver or issue for delivery a long-term care insurance policy in this state unless the insurer offers to the policyholder, in addition to any other inflation protection, the option to purchase a long-term care insurance policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a long-term care insurance policy containing an inflation protection feature which is no less favorable than one that does one or more of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5 percent.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.

SEC. 20. Section 10237.4 is added to the Insurance Code, to read:

10237.4. (a) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(b) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

SEC. 21. Section 10237.5 is added to the Insurance Code, to read:

10237.5. (a) An inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(b) The rejection, to be included in the application or on a separate form, shall state:

''I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specially, I have reviewed the plan, and I reject inflation protection.

_____ _____

Signature of Applicant Date''

SEC. 22. Section 10237.6 is added to the Insurance Code, to read:

10237.6. (a) An insurer shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical or graphic demonstration for purposes of this disclosure.

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